

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 760

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
Water Cliff St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Water Cliff St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

James Vance Albright

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) 3 July 1933 8.(c) If alive, give age years

8. AGE: Years 12 Months 10 Days 5 If less than one day hrs. min.

9. Birthplace Frostburg-Allegany-Maryland
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

12. Name William Albright

13. Birthplace Vale Summitt, Maryland

14. Maiden name Gertrude Goldsworthy

15. Birthplace Lonaconing, Maryland

16. Informant William Albright

Address Lonaconing, Md

17. Burial Date thereof May 11 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Maryland

18. Funeral director Ellsworth S. Boal

Address 111 Church St, Westernport, Md.

19. May 10 - 1946 Dr. E. D. Jones
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 May 19 46 10:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 7 19 46 to May 8 19 46

and that I last saw him alive on May 3 19 46

Immediate cause of death Chronic Rheumatic Endocarditis, Myocarditis, and pericarditis

Due to Acute Rheumatic Fever

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson M.D.
M. D. or other

Address Piedmont, W. Va. Date signed 10 May 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 13 1946
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

04400

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 hours and 45 min.
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 6hrs. 45min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEG.
 City or town R. D. #2 CUMBERLAND, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. #1
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MRS. MAE BARGER

3. (b) Social Security Number

220-10-7794

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED
 6.(b) Name of husband or wife LOSTEN E. BARGER
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) FEBRUARY 24, 1916
 8. AGE: Years 30 Months 2 Days 21 It less than one day _____ hrs. _____ min.

9. Birthplace MARYLAND
 (Town, county, and state)
 10. Usual occupation HOUSEWORK
 11. Industry or business _____
 12. Name JOSEPH STAFFORD
 13. Birthplace MD.
 14. Maiden name ELSIE L. RICE
 15. Birthplace MD.

16. Informant Mr. J. B. Stafford
 Address R. D. #2 Williams Rd. Cumberland
Burial Date thereof May 19, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Herman
 Location Williams Rd. Near Cumberland,
Charles L. George
 18. Funeral director _____
 Address Cumberland, Md.

19. May 18, 1946 Joseph P. Franklin M.D.
 (Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1946 at 7 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1946 to May 12, 1946
 and that I last saw him alive on May 15, 1946

Immediate cause of death Dilated Myocardium DURATION 3 years

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Joseph P. Franklin M.D. M. D. or other _____
 Address Cumberland, Md. Date signed 5-18-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1945

BUREAU V.S.

DR. VANORMER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore, Md.

04401

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 811 FAYETTE ST.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

MR. GEORGE L. BARKER

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife... ANN ELIZABETH BARKER

8. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 30, 1883

8. AGE: Years Months Days If less than one day

63 2 0 hrs. min.

9. Birthplace... SCOTLAND
(Town, county, and state)

10. Usual occupation... UNEMPLOYED

11. Industry or business

12. Name... GEORGE L. BARKER

13. Birthplace... EGYPT

14. Maiden name... ISABELLA BALELOUR

15. Birthplace... SCOTLAND

16. Informant... MEMORIAL HOSPITAL

Address... CUMBERLAND, MD.

17. Burial Date thereof June 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rose Hill Cemetery

Location... Cumberland, Md.

18. Funeral director... William H. Knight

Address... Cumberland, Md.

19. June 1, 1946 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... MAY 30, 1946, at 11:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 May 1946, to 30 May 1946, and that I last saw him alive on 30 May 1946.

Immediate cause of death... Chronic nephritis with cerebral aneurysm? Cerebral aneurysm

Due to

Due to

Other conditions... Chronic myelitis with Cardiac Hypertrophy

(Include pregnancy within months of death)

Major findings of autopsy... Corrosion of liver

Cardiac Hypertrophy Date of op. 5/31/46

Physician: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. Alfred V. Ome, M.D.

Address... Cumberland, Md. Date signed 1946/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1946

BUREAU V.B.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

04402

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 59 Years
Hospital, institution, or street address where death occurred:
339. Frederick St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 339. Frederick St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Jane Barnett
4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

None

6.(b) Name of husband or wife

George Barnett

7. Birth date of deceased (mo., day, yr.)

October 15 1886

8.(c) If alive, give age years

8. AGE: Years 59 Months 7 Days 1 If less than one day
hrs. min.

9. Birthplace

Cumberland, Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

Own House

FATHER

12. Name Charles Darr
13. Birthplace Petersburg, W. Va.

MOTHER

14. Maiden name Ellen Spillard
15. Birthplace Petersburg, W. Va.

18. Informant

George Barnett

Address 339. Frederick St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof

5/19/46
(month) (day) (year)

Cemetery or crematory Sumner Cemetery

Location Cumberland, Md.

18. Funeral director

William H. Kight

Address Cumberland, Md.

19. May 18, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 16 1946 at 430 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1945 to May 16 1946
and that I last saw him alive on May 16 1946

Immediate cause of death

Coronary Coronary
and atherosclerosis
Caloria

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (Where?)

Means of injury

Injured at work?

23. SIGNATURE R. D. Markers M. D. or other

Address 49 Greene St Date signed 5-17-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

04403

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegheny
 City or town Oldtown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 71 years
 Hospital, institution, or street address where death occurred:
Oldtown, Md
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Allegheny
 City or town Oldtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Mary E. Barth

3(b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife John G. Barth
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 16, 1874
 8. AGE: Years 71 Months 6 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Oldtown Allegheny, Md
 (Town, county and state)
 10. Usual occupation Housewife
 11. Industry or business Own home
 12. Name James Wilson
 13. Birthplace Flintstone, Md.
 14. Maiden name Jeannette Daniels
 15. Birthplace Maryland

16. Informant Jeannette G. Davis
 Address Oldtown, Md.

17. Burial Date thereof May 13, 1946
 (Burial, cremation, or removal. Which?) _____ (month) (day) (year)
 Cemetery or crematory Wilson Cemetery
 Location Near Oldtown, Md

18. Funeral director John J. Hefner
 Address Cumbersland, Md.

19. May 13, 1946 Mrs. C. A. Shankolt
 (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1946 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1942 to May 11, 1946
 and that I last saw him alive on May 3, 1946

Immediate cause of death congestive heart failure DURATION 2 years

Due to chronic myocarditis DURATION 3 years

Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE L. Morris MD M. D. or other _____
 Address Long Mt Date signed 5/13/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DEATH CERTIFICATE

RECEIVED
MAY 20 1946
BUREAU V.S.

Within corporate limits

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

04404

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 YEARSHospital, institution, or street address where death occurred:
MEMORIAL HOSPITALHow long in hospital or institution? 27 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 21 N. ALLEGANY ST.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

MR. NORMAN SAMUEL BIRCH

3. (b) Social Security Number

350-07-5446

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife LOIS SPEICHER6. (c) If alive, give age 26 years7. Birth date of deceased (mo., day, yr.) NOV. 29 19038. AGE: Years 42 Months 5 Days 20 If less than one day
..... hrs. min.9. Birthplace PENNSYLVANIA
(Town, county, and state)10. Usual occupation OWNER OF TRI-STATE11. Industry or business DETECTIVE AGENCY12. Name SAMUEL BIRCH13. Birthplace PENNSYLVANIA14. Maiden name MINNIE ZIMMERMAN15. Birthplace NEW YORK16. Informant MEMORAIL HOSPITALAddress CUMBERLAND, MD.17. BURIAL Date thereof MAY 21 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ROSE HILL CEM.Location CUMBERLAND MD.18. Funeral director LOUIS STEIN INC.Address CUMBERLAND MD.19. May 21, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 19 1946 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 22 1946 to May 19 1946and that I last saw him alive on May 18 1946Immediate cause of death Parasitomatosis

DURATION

Due to Primary carcinoma of intestinesDuration not stated. Que. B.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Large amount of fluidmasses + nodules Date of op. May 17-46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. G. Gracie M. D. or otherAddress Cumberland Md Date signed May 19-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 04405 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 46 Years

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rt. #2, Cumberland rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If yataran, nama war _____

3. (a) FULL NAME

Mrs. Daisy Bohrer

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife Howard Bohrer6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) July 13, 18788. AGE: Years Months Days If less than one day
67 9 26hra.min.9. Birthplace Berkeley Springs, W. Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Deceased Joshua Bohrer13. Birthplace Berkley Springs, W. Va.14. Maiden name Deceased Sarah Jane Bohrer15. Birthplace Berkley Springs, W. Va.16. Informant Boyd F. BohrerAddress 227 Arch Street, Cumberland, Md.17. Burial Date thereof May 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Maryland18. Funeral director William H. KightAddress Cumberland, Maryland19. May 10, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 19 46 at 1:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to May 9, 1946and that I last saw him alive on May 9, 1946Immediate cause of death Carcinoma of sigmoid colon DURATION 3 months

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of sigmoid colon Date of op. 5-16-46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE J. P. Franklin, M.D. D. or other _____Address Cumberland, Md. Date signed 5-9-46

RECEIVED
MAY 14 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04406

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Allegheny
 City or town Near Cumberland rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt. 3, Bourns Addn
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

George Haron Bowman

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Elizabeth A Bowman

7. Birth date of

deceased (mo., day, yr.)

October 10, 1856

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

8978

hrs.

min.

9. Birthplace

Paw Paw, W. Va.

(Town, county, and state)

10. Usual occupation

Building contractor

11. Industry or business

Self.

MOTHER

FATHER

12. Name

George Bowman

13. Birthplace

Germany

14. Maiden name

Johnson

15. Birthplace

Chaneysville, Pa.

16. Informant

Winnar Bowman

Address

Rt. 3, Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 21, 1946
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Wager

Address

Cumberland, Md.

19. May 20, 1946

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 18, 1946, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10, 1946 to May 18, 1946and that I last saw him alive on April 17, 1946

Immediate cause of death

Myocardial Infarction

DURATION

7 Days

Due to

Myocardial Infarction2 yrs

Due to

Myocardial Infarction2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. A. Howard

M. D. or other

Address

Cumberland MdDate signed 4-5-46

RECEIVED

MAY 28 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1760

CERTIFICATE OF DEATH

04407

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3/4/46 to 3/6/46
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war. _____

3. (a) FULL NAME Jeremiah

3. (b) Social Security Number Burkholder

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife. _____
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Not Known 1865
8. AGE: Years 81 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Bittinger, Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business _____
12. Name John Burkholder
13. Birthplace Bittinger, Md.
14. Maiden name Lydia Bittinger
15. Birthplace Bittinger, Md.
16. Informant Noeh Bittinger
Address Swanton, Md.

17. Burial Date thereof May 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cemetary (Brothern)
Location Brothern Cem. Rural, Bittinger Md
18. Funeral director Wm Wintenberg
Address Swantonville Md
19. 5-4 46 Mrs. Nancy H. Roe
(Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH May 6 19 46 at 3:50 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 19 46 to May 6 19 46
and that I last saw him alive on May 6 19 46
Immediate cause of death
Contusion chest
fracture scalp
fracture l radius + ulna
DURATION
2 1/2 days
2 1/2 hrs
2 1/2 "
Due to _____
Other conditions Arteriosclerosis
(Include pregnancy within 8 months of death)

Major findings of operations _____
Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5/3/46
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) public highway
Means of injury Struck by automobile (How?) _____

23. SIGNATURE Hilda J. Walters M.D.
Address Frostburg M. D. or other _____
Date signed 3/6/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 9 1946

BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

04408

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 214 Fayette St.
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

Baby Boy Busch

3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Infant</u>
-----------------------	----------------------------------	---------------------------------------------------------------

B. (b) Name of husband or wife.....
B. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) May 12, 1946
8. AGE: Years Months Days If less than one day
5 hrs. min.

9. Birthplace... Cumberland, Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER	12. Name... <u>John A. Busch</u>
	13. Birthplace... <u>Ohio</u>
MOTHER	14. Maiden name... <u>Mary C. Lawler</u>
	15. Birthplace... <u>Cumberland, Md.</u>

16. Informant... Mrs. Lillian Lawler
Address... 214 Fayette St. Cumberland, Md.

17. Burial Date thereof... May 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory... S.S. Peter & Paul
Location... Cumberland, Md.

18. Funeral director... Charles L. George
Address... Cumberland, Md.

19. May 14, 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 13 19 46 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 12 19 46 to May 13 19 46
and that I last saw h... alive on... 19...

Immediate cause of death... premature delivery
DURATION... One day

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operation.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... L. Brins M.D. or other

Address... Long Hill Date signed... 5-13-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town East Jefferson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County Bedford
 City or town Hendricks
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Sarah Elizabeth Bush

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

George Bush

7. Birth date of

deceased (mo., day, yr.)

September 21, 1862

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

83

8

4

hrs. min.

9. Birthplace

Hendricks Pa.
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Jacob Welles

13. Birthplace

Pa.

14. Maiden name

Lessie Shroyer

15. Birthplace

Pa.

16. Informant

Mr. Charles Earl Bush

Address

Hendricks Pa.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 27, 1946
 (month) (day) (year)

Cemetery or crematory

Hendricks

Location

Hendricks Pa.

18. Funeral director

Harvey H. Zeigler

Address

Hendricks Pa.

19.

(Date rec'd by registrar)

May 27, 1946

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 25 1946 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to May 1946

and that I last saw her alive on May 24 1946

Immediate cause of death

Congestive heart failure

DURATION

1 mo.

Due to

Chronic arterio-sclerotic

70 yrs.

Due to

Heart disease with

1 mo.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John A. Lippert M.D.

M. D. or other

Address Hendricks Pa. Date signed May 25, 46

RECEIVED

JUN 4 1946

BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

73d

04410



Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital, Cumberland, Maryland
How long in hospital or institution? 33 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Mrs. Fannie Collins
3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Taylor Collins
7. Birth date of deceased (mo., day, yr.) September 26th, 1874 8.(c) If alive, give age _____ years
8. AGE: Years 71 Months 7 Days 16 It less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION
20. DATE OF DEATH 5/12 19 46 at 9:06 P.M.

9. Birthplace Loudoun County, Va.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Isaac Nichols
13. Birthplace Va.
MOTHER 14. Maiden name Martha McDonald
15. Birthplace Va.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 9 19 46 to May 12 19 46
and that I last saw her alive on May 11 19 46
Immediate cause of death _____ DURATION _____

16. Informant Mrs. Henry Lynch
Address 421 Central Ave. Cumberland, Md.
Burial Meth. Church Cem. Date thereof May 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Three Churches, W. Va.
Location Charles L. George
18. Funeral director Cumberland, Md.
Address
19. May 15, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Chronic Myocarditis 1 year
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE R. H. Turnastis, Jr. M.D. M.D. or other _____
Address Cumberland, Md. Date signed May 14 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year MARYLAND STATE DEPARTMENT OF HEALTH

04411

In corporate Name of deceased is shown on

2411 N. Charles St., Baltimore (B12)

FILM No. I 04 MAY 15 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County alliganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

923 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County alliganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 923 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles W. Crupper

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Sophie Dreyer

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

April 16 1886

8. AGE:

Years

Months

Days

If less than one day

80112

hrs.

min.

9. Birthplace

Paris, Va.
(Town, county, and state)

10. Usual occupation

Carpenter (Retired)

11. Industry or business

Baltimore & Ohio P. R.

12. Name

William Crupper

13. Birthplace

Va.

14. Maiden name

Anna Davis Crupper

15. Birthplace

Va.

16. Informant

Mrs. Charles W. Crupper

Address

Cumberland Ind.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

May 6 1946
(month) (day) (year)

Cemetery or crematory

Trinity Lutheran

Location

Cumberland Ind.

18. Funeral director

Louis Stein Inc.

Address

Cumberland Ind.

19. May 4, 1946

(Date rec'd by registrar)

J. P. Franklin M. D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1946 at 9:30 AM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1 1946 to May 3 1946and that I last saw him alive on Apr 29 1946Immediate cause of death Coronary Thrombosis DURATION SuddenDue to Organic Heart DiseaseDue to Thrombotic Thrombosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos A. Brown M. D. or otherAddress Cum husband Ind Date signed 453

RECEIVED

MAY 7 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

U4412

Reg. Dist. No.

DR DURRETT

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 4 DAYS3. (a) FULL NAME Joseph Dastoli
JOSEPH DASTOLI3. (b) Social Security Number
217-05-7350

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITESingle

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1889?

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
57 hrs. min.9. Birthplace Italy
(Town, county, and state)10. Usual occupation Coal Miner11. Industry or business Garrett Coal Co. Kitzmiller, Md.12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.17. Burial Date thereof May 8, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Kalbaugh CemeteryLocation Elk Garden, W. Va.18. Funeral director William H. KightAddress Cumberland, Md.19. May 6, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County GARRETTCity or town KITZMILLER, MD.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 6 1946 at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2, 1946 to May 6, 1946
and that I last saw him alive on May 5, 1946

Immediate cause of death

acute hyperphosphatemia

DURATION

2 wks.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

May 6, 1946
Address Cumberland Date signed 5/6/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

MAY 14 1946

BUREAU

Outside of City Limits

Outside limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46f

04413

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
Rt. 4, Oldtown, Pa.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Pa County Allegheny
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #4, Oldtown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Henrietta King "Stout" DuVall

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife William Howard DuVall
6. (c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) July 22, 1875
8. AGE: Years 70 Months 10 Days 0 It less than one day
.....hrs.min.

9. Birthplace Mt Vernon, Prince William, Va
(town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
12. Name William H. Stout
13. Birthplace Pennsylvania
14. Maiden name Rebecca Davis
15. Birthplace Virginia

16. Informant Claude DuVall
Address Rt. 4, Cumberland, Md
17. Burial Date thereof May 24, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Tabor Cemetery
Location Near Spring Gap

18. Funeral director John J. Hefner
Address Cumberland, Md.
19. May 24, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1946 at 10:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....19..... to May 22, 1946
and that I last saw her alive on19.....
Immediate cause of death Carcinoma
of Liver
? ?
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

DURATION

1 yr

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE WR Hodges, M.D. M. D. or other
Address Cumberland, Md Date signed 5/23/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 980

CERTIFICATE OF DEATH

04414

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 269 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

6.(a) Single, married, widowed, or divorced

6.(c) If alive, give age 81 years7. Birth date of deceased (mo., day, yr.) Dec 18 - 18638. AGE: Years 82 Months 4 Days 23 If less than one day hrs. min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Retired Painter11. Industry or business Gelatin Corp.12. Name George Eisel13. Birthplace Germany14. Maiden name Maria Baum15. Birthplace Germany16. Informant George EiselAddress 118 Virginia St. Cumberland17. (Burial, cremation, or removal, Which?) Burial Date thereof May 14 - 1946
(month) (day) (year)Cemetery or crematory AlleghenyLocation Frostburg19. Funeral director Joseph G. GagerAddress Frostburg19. 5-13 46 Md. May 14 1946
(Date rec'd by registrar) Registrar

3.(b) Social Security Number

2 20-10-4551

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1946 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 11 1946 to May 11 1946and that I last saw him alive on May 11 1946Immediate cause of death Acute myocarditisDue to Arterio-sclerosisDue to SenilityDue to Chronic prostatitis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. Diehl, M.D.Address Frostburg, Md. Date signed 5/13/46

RECEIVED
MAY 15 1948
BUREAU V.R.

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

★ 04415

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
Trt 3, Union Grove
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Allegheny
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Trt 3, Union Grove
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Addison H. Eyler

3.(b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Jarot "Wolfe" Eyler
6.(c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) January 4, 1872
8. AGE: Years 74 Months 4 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Hazen, Allegheny, Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Retail Merchant
FATHER 12. Name Robert T. Eyler
13. Birthplace Burmont, Md
MOTHER 14. Maiden name Caroline Hendrickson
15. Birthplace Hazen, Md.

16. Informant Mrs. John Westling
Address Trt 3, Cumberland
17. Burial Date thereof May 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Zion Memorial Park
Location Cumberland, Md.

18. Funeral director John J. Hefner
Address Cumberland, Md.
19. May 13, 1946 J.P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1946, at 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 30 1945 to May 9 1946
and that I last saw him alive on May 9 1946
Immediate cause of death Cerebral Hemorrhage
Due to arteriosclerosis
Due to _____
Other conditions _____

DURATION

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE D. Keeler M. D. or other _____
Address 1204 46th Street, Bklyn, Sp Date signed 5/12/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2058

RETURN TO THE SECRETARY OF THE ARMY

Department of the Army

WASHINGTON, D. C.

RECEIVED

RECEIVED

MAY 21 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

04416

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Burnsland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:573 Frank's Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Burnsland
(If outside city or town limits, write RURAL and give nearest town)Street No. 573 Frank's Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William J. Fargrieve

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Anna Hitchens7. Birth date of deceased (mo., day, yr.) July 4 1867

6. (c) If alive, give age years

8. AGE: Years 78 Months 10 Days 16 If less than one day
hrs. min.9. Birthplace Boston Ind
(Town, county, and state)10. Usual occupation Ironer

11. Industry or business

12. Name Wm. Fargrieve13. Birthplace USA14. Maiden name Christine Watts15. Birthplace USA16. Informant Mrs. Isabel SquiresAddress 573 Frank's Lane, Burnsland17. Burial (Burial, cremation, or removal, which?) Date thereof May 22 '46
(month) (day) (year)Cemetery or crematory Allegany Cem.Location Burnsland Ind18. Funeral director Gunn's Stein & CoAddress Burnsland md19. May 22 19 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 46 at 12:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 42 to May 20 19 46and that I last saw him alive on May 20 19 46Immediate cause of death Stroke

DURATION

2 wksDue to Chronic asthma5 yrsDue to Myocarditis3 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton J. Fargrieve M. D. or otherAddress Burnsland Date signed May 21, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7-10

RECEIVED
MAY 28 1946
BUREAU V.S.

Handwritten notes and signatures, including "17-10" and "17-10" in the bottom right corner.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9402

CERTIFICATE OF DEATH

★ 04417
Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred
Brown St. R. & G. Taylor Fin Plate Mill

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Braddock Rd. Rr. 5
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank W. Fishel

3. (b) Social Security Number

717-10-4734

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mary G. Holt 6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) May 31, 1903
8. AGE: Years 42 Months 11 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace N. Va.
(Town, county, and state)
10. Usual occupation Trachinist
11. Industry or business Claness Corp. of A.
12. Name Jacob H. Fishel
13. Birthplace N. Va.
14. Maiden name Prinnie Winfield
15. Birthplace N. Va.16. Informant Mrs. Mary Holt Fishel
Address Rr. 5 Cumberland Ind
17. Burial Date thereof May 14 46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Methodist Cem.
Location Outsavage Ind.
18. Funeral director Louis Stein Inc
Address Cumberland
19. May 14, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th., 1946 at 2.45 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____,
and that I last saw him _____ alive on _____ 19_____.Immediate cause of death Coronary Occlusion
Due to _____
Due to _____
Other conditions _____

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____23. SIGNATURE Ernest H. Benson, M.D.
Address Cumberland, Maryland M. D. or other 5-10-46
Deputy Medical Examiner : Allegany Co

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V S

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

CERTIFICATE OF DEATH

04418

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred: La Vale
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. La Vale - A. Hwy #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Florence Virginia Fisher

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Sanford S. Fisher 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 30 1866

8. AGE: Years 79 Months 5 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Ind
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name Henry Miller

13. Birthplace Ind

14. Maiden name Mary Young

15. Birthplace Ind.

16. Informant Mrs. Jas. Orason

Address Cumberland

17. Burial Date thereof May 13 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cln

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

May 13 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1946 at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to May 10 1946

and that I last saw him alive on May 10 1946

Immediate cause of death Cardio-Renal Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Bailey Hunter M.D. M. D. or other

Address Cumberland Md Date signed 5/11/46

MARGIN RESERVED FOR BINDING

(I)

VS A15- 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 1 day

3. (a) FULL NAME

Phillip Fletcher

3. (b) Social Security Number

705-10-7226

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

Etta Price Fletcher6. (c) If alive, give age 50 years

7. Birth date of

deceased (mo., day, yr.)

Oct. 8, 1887

8. AGE:

Years

Months

Day

It less than one day

58626

— hrs.

— min.

9. Birthplace

Little Orleans Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

Railroader

11. Industry or business

FATHER

12. Name

Franklin Pierce Fletcher

13. Birthplace

Penna.

MOTHER

14. Maiden name

Rebecca Norris

15. Birthplace

Allegany Co., Md.

16. Informant

Allan F. Fletcher

Address

Little Orleans, Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof May 8, 1946
(month) (day) (year)

Cemetery or crematory

Big Ridge Church of God

Location

Little Orleans, Md.

18. Funeral director

Charles R. Bast

Address

Hancock, Md.

19.

May 7, 1946
(Date received by registrar)J. P. Franklin, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Little Orleans
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

—

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th., 1946 at 6:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Extensive second and third degree burns of head, face, neck and extremities.

DURATION

22 hrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-3-46Where did injury occur? Belle Grove, Allegany, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) highwayMeans of injury collision of truck and auto
Injured at work? no

23. SIGNATURE

James H. Brown, M.D.
M. D. or otherAddress Cumberland, MarylandDate signed 5-5-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1946

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1275)

04420

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
53 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 53 Greene St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rosa Lillian Fuller

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
6. (b) Name of husband or wife... <u>Howard M. Fuller</u>		
7. Birth date of deceased (mo., day, yr.) <u>Feb. 18, 1870</u>		
8. AGE: Years <u>76</u>	Months <u>2</u>	Days <u>19</u>
6. (c) If alive, give age... years hrs. min.		

9. Birthplace... Winchester, Va.
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

FATHER	12. Name... <u>John N. Kane</u>
	13. Birthplace... <u>Winchester, Va.</u>
MOTHER	14. Maiden name... <u>Margaret A. Boyce</u>
	15. Birthplace... <u>Winchester, Va.</u>

16. Informant... Miss. Mira Fuller
 Address 53 Greene St. Cumberland, Md.

17. Burial Date thereof May 10, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Rose Hill Cemetery
 Location... Cumberland, Md.

18. Funeral director... Charles L. George
 Address Cumberland, Md.

19. May 10, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 7, 1946 at 6:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 7, 1946, to May 7, 1946
 and that I last saw him alive on May 7, 1946

Immediate cause of death... Bronchopneumonia
 DURATION 5 days

Due to

Due to

Other conditions... Cholelithiasis
 (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Blaine M. Schmidt

M. D. or other

Address... 41 Greene St. Cumberland, Md. Date signed... May 9, 1946

RECEIVED

MAY 14 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-MD

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 67 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany
~~State~~ Cumberland, rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Bowling Green
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Blaine Gallimore

3. (b) Social Security Number

217-10-5423

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MWMarried6. (b) Name of husband or wife Sara Sayers Gallimore6. (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) 5-26-1883

8. AGE: Years 63 Months 0 Days 4 If less than one day
 hrs. min.

9. Birthplace Va. (Pulaski)
(Town, county, and state)10. Usual occupation Police11. Industry or business Celeanese Corp. Of America12. Name David W. Gallimore13. Birthplace Va.14. Maiden name Ann McGee15. Birthplace Va.16. Informant Mr. Blaine C. Gallimore Jr.Address P.O. Box 862 Cumberland, Md.17. Burial Date thereof June 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. June 1, 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 46 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10 p.m. 46 to 30 May 46
 and that I last saw him alive on 29 May 46

Immediate cause of death

1. Malignancy of heart with metastasis to lung.

DURATION

Due to Malignancy of gastrointestinal tract.

Due to 2. Malignant Hypertension
3. Hypertensive Heart Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results None not permitted
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Van Ormer, M.D. M. D. or otherAddress Cumberland, Md. Date signed 30 May 46618 Washington St.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1946

BUREAU V S

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *512*

CERTIFICATE OF DEATH

04422

Reg. Dist. No. *4*

1. PLACE OF DEATH:

County *Allegany*
City or town *Rural Cumberland, Rural*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
R.D.#3, Bedford road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Allegany*
City or town *Rural Cumberland, Rural*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *R.D.#3, Bedford road*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Harry Clayton Gillum

3. (b) Social Security Number

None

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
8. AGE: Years *67* Months *11* Days *5* If less than one day
11. Industry or business *Carpenter*

9. Birthplace *Bedford Valley, Penna.*
(Town, county, and state)

10. Usual occupation *Retired*

12. Name *John Gillum*

13. Birthplace *Penna.*

14. Maiden name *Victoria Bruner*

15. Birthplace *Penna.*

16. Informant *Mrs. Myrtle Gillum*

Address *R.D.#3 Cumberland, Md.*

17. Burial Date thereof *May 14, 1946*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Zion Memorial Cem.*

Location *Bedford Road*

18. Funeral director *Charles L. George*

Address *Cumberland, Md.*

19. *May 14, 1946* *J.P. Franklin, M.D.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 11, 1946* at *11 A.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him *alive* on *19*

Immediate cause of death *Carcinoma of Prostate 6 yrs.* DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Dr. Poole Hodges* M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04423

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
7 Virginia Ave.
How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town East Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Allegany Brook
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Paul F Goldsworthy

3. (b) Social Security Number

216-22-7316

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Margaret Spence
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) June 5 1873
8. AGE: Years 77 Months 11 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Groethburg Ind.
(Town, county, and state)

10. Usual occupation Real estate agent

11. Industry or business

12. Name Paul Goldsworthy

13. Birthplace England

14. Maiden name Mary Ellen Cosgrove

15. Birthplace Barton, Maryland

18. Informant Paul R Goldsworthy

Address La Vale, Ind

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof May 21 1946
(month) (day) (year)

Cemetery or crematory St P.O.P. Cem.

Location Cumberland Ind

18. Funeral director Louis Stein Inc

Address Cumberland Ind

19. May 20 19 46 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 19 46 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 46 to May 17 19 46

and that I last saw alive on May 12 19 46

Immediate cause of death congestive heart failure

Due to chronic myocarditis

Other conditions apoplectic stroke

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Whisen M.D.

Address La Vale, Ind

Date signed 5-19-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1946

BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-F

CERTIFICATE OF DEATH

04424

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cambsland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For infants give residence of mother)

State Maryland County Allegany

City or town Cambsland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 329 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Gunter

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

8.(b) Name of husband or wife Sadie Roman

7. Birth date of deceased (mo., day, yr.) November 17 1873 8.(c) If alive, give age 72 years

8. AGE: Years 72 Months 6 Days 10 If less than one day hrs. min.

9. Birthplace Ind.
(Town, county, and state)

10. Usual occupation Engineer (Retired)

11. Industry or business B & O Ry.

12. Name Wm. Gunter

13. Birthplace Wales

14. Maiden name Anna Stewart

15. Birthplace Wales

16. Informant Wm. Gunter

Address Cambsland

17. Burial May 29 46
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem

Location Cambsland

18. Funeral director Louis Stein Inc

Address Cambsland

19. May 28 1946 Joseph P. Dangler, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1946 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1946 to May 27 1946

and that I last saw him alive on May 26 1946

Immediate cause of death Cerebral Thrombosis

DURATION

4-5 hrs

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alfred Mason

126 Yellow Rd. Cambsland Md M. D. or other

Address Date signed May 28 1946

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MINISTER OF TRANSPORTATION

CERTIFICATE OF REGISTRATION

RECEIVED
JUN 4 1946
BUREAU V. 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04425

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
200 Decatur St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 200 Decatur St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Violet Cecelia Haenftling

3. (b) Social Security Number

214-07-2648

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 11, 1918
 8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

28117

hrs.

min.

9. Birthplace Little Orleans, Allegheny, Md.
 (Town, county, and state)

10. Usual occupation Silt worker11. Industry or business Celanese Corp12. Name Gilbert E. Haenftling13. Birthplace Accident, Md.14. Maiden name Emma E. Apple15. Birthplace Little Orleans, Md.16. Informant Theodore HaenftlingAddress Cumberland, Md

17. Burial Date thereof May 31, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director Phy J. NofusAddress Cumberland, Md

19. May 31, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19, 1946 to May 28, 1946and that I last saw her alive on May 28, 1946

Immediate cause of death

Scarlet fever

DURATION

Due to Scarlet fever

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M.E.B. OwensAddress 133 Va Ave

M. D. or other

Date signed 5/30/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1946

BUREAU V.E.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. LONG, MARYLAND La Vale
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

HARDMAN, CLINTON M. MR.

3.(b) Social Security Number

212-24-2440

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWER6.(b) Name of husband or wife BRASHEARS, BESSIE

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

FEB. 1 1873

8. AGE:

Years

Months

Days

If less than one day

7336

hrs.

min.

9. Birthplace Bedford Co Pa.
(Town, county, and state)10. Usual occupation RETIRED

11. Industry or business

Construction School

FATHER

12. Name HARDMAN, LEVI

13. Birthplace

PA.

MOTHER

14. Maiden name

Smith, MARY

15. Birthplace

PA.16. Informant Reese Hardman

Address

Cumberland17. Burial Date thereof May 10 46
(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory

Fullcross Cem.

Location

Cumberland

18. Funeral director

Louis Stein Dns

Address

Cumberland19. May 8, 46 J. P. Frankie, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 7, 1946 at 9:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 24, 1946 to May 7, 1946and that I last saw him alive on May 7, 1946

Immediate cause of death

DURATION

Lymphatic Leukemia3 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or otherAddress 110 S. Centre St. Date signed 5-8-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (M&A)

04427

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... life
 Hospital, institution, or street address where death occurred:
 Allegany Hospital
 How long in hospital or institution?..... 1 Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 210 Maryland Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Albert G. Harsh

3. (b) Social Security Number

705-07-9671

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 21, 1899

8. AGE:	Years	Months	Days	If less than one day
46	10	29	hrs.	min.

9. Birthplace..... Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation..... Carman Helper

11. Industry or business..... B & O Railroad

FATHER	MOTHER
12. Name..... Aquilla Harsh	14. Maiden name..... Mary Dayton
13. Birthplace..... Martinsburg, W. Va.	15. Birthplace..... Keyser, W. Va.

16. Informant..... James F. Harsh
 Address..... 53 Race St. Brownsville, Pa.

17..... Burial..... Date thereof..... May 23, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Hill Crest Cemetery
 Location..... Cumberland, Md.

18. Funeral director..... William H. Kight
 Address..... Cumberland, Md.

19..... May 23, 1946..... J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about P.

20. DATE OF DEATH..... May 20th., 1946, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....
 Coronary Occlusion

Due to.....

Due to.....

Other conditions..... Laceration scalp of occiput,
 sustained in falling to street.
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... no autopsy
 PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... James H. Brown, M.D.
 M. D. or other
 Address..... Cumberland, Maryland, Date signed..... 5-21-46

Deputy Medical Examiner : Allegany Co

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 25 1946
BUREAU VS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

04428

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Allegany Hospital-Cumberland, Md.
How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State W. Va. County Mineral
City or town Ridgeley
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Perry Street
(If rural, give LOCATION) ✓
2.(a) If veteran, name war

3. (a) FULL NAME

George Hershberger

3. (b) Social Security Number

NONE

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Martha Hershberger
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 26, 1868
8. AGE: Years 77 Months 10 Days 17 If less than one day _____ hrs. _____ min.

8. Birthplace Fairmont, W. Va.
(Town, county, and state)

10. Usual occupation Conductor (Retired)

11. Industry or business W. M. R. R.

12. Name John Hershberger

13. Birthplace Cumberland, Md.

14. Maiden name Mary Rogers

15. Birthplace Unknown

16. Informant Mrs. Martha Hershberger

Address 11 Perry St. Ridgeley, W. Va.

17. Burial Date thereof May 20, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. May 18, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 19 46, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 9 19 46, to May 17 19 46
and that I last saw him alive on May 16, 1946 19 46

Immediate cause of death _____

Pneumo-Pneumonia 4 days

Due to Secondary arteriosclerosis years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Blane M. Schneider M.D. M. D. or other

Address 41 Green St. Cumberland Date signed May 17/46

RECEIVED
MAY 21 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

Reg. Dist. No. 9

04429

1. PLACE OF DEATH:

County Allegany
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 yrs.
 Hospital, institution, or street address where death occurred:
Miners Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Allegany
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Jerry Jordan Robinson

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

8. (b) Name of husband or wife John Robinson

7. Birth date of deceased (mo., day, yr.) Nov. 6th. 1871 8. (c) If alive, give age _____ years

8. AGE: Years 74 Months 11 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Anthon, Garrett, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Stark

13. Birthplace Scotland

14. Maiden name Jessie Robinson

15. Birthplace Scotland

16. Informant Mrs. Jean Robinson

Address Frederick, Md.

17. Burial Date thereof 5-13-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Charles Cemetery

Location Frederick, Md.

18. Funeral director Jacob Wagner

Address Frederick, Md.

19. 5-11 19 46 Mrs. Honey A. De
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 19 46 at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 19 46 to May 10th 19 46

and that I last saw him alive on May 10th 19 46

Immediate cause of death _____ DURATION _____

Chronic Hypertension, several months

Due to _____

hypertension several years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. M. Lane M. D. or other _____
 Address Frederick, Md. Date signed 5-11-46

RECEIVED
MAY 15 1945
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

04430

Reg. Dist. No. 4

1. PLACE OF DEATH:
 County Allegany
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Allegany Hospital, Cumberland, Maryland
 How long in hospital or institution? 108 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Rural, Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. LaVale
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME
Mr. John J. Howe

3.(b) Social Security Number
705-09-3513

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Mrs. Bertie Howe

7. Birth date of deceased (mo., day, yr.) 3/17/1887 1867 B.(c) If alive, give age years

8. AGE: Years 79 Months 1 Days 16 If less than one day hrs. min.

9. Birthplace England
 (Town, county, and state)

10. Usual occupation Retired - Roll Designer

11. Industry or business B. & O. R.R. Co.

12. Name Jonathan Howe

13. Birthplace England

14. Maiden name Catherine Edwards

15. Birthplace Wales

16. Informant Mrs. Bertie Howe

Address La Vale, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1946
 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. May 6, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3 19 46 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 19 46 to May 3 19 46 and that I last saw him alive on May 3 19 46

Immediate cause of death encephalomalacia

Due to cerebral hemorrhages DURATION

Due to

Other conditions bronchopneumonia
 (terminal)
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabeth Krump, M.D.
Long, Md. M.D. or other
 Address Date signed 5/5/46

RECEIVED

MAY 14 1946

BUREAU V. M.

ARRESTED IN THE

RAG CONTENT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-C

CERTIFICATE OF DEATH

Reg. Dist. No. 04431 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 week
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Allegany
 City or town Cresaptown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Ernest Jones

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Child

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb 6, 1946

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

0323

hrs.

min.

9. Birthplace

Cumberland Allegany Co., Md
(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

MOTHER FATHER

12. Name

Wilford D. Jones

13. Birthplace

New Castle Pa.

14. Maiden name

Willavene Gray

15. Birthplace

New Castle Pa.

18. Informant

Wilford D. Jones

Address

Cresaptown Md.

17. Removal or Burial (Burial, cremation, or removal. Which?)

Date thereof

June 1, 1946
(month) (day) (year)

Cemetery or crematory

Oak Park Cemetery

Location

New Castle Pa.

18. Funeral director

John J. Hoyer

Address

Cumberland Md.

19. May 30 1946

J. P. Franklin, M.D.

Registrar

(Date rec'd by registrar)

Dr. Louis Brings

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1946, at 3:29 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1946 to May 29 1946 and that I last saw him alive on May 28 1946

Immediate cause of death

peritonitis

DURATION

5 days

Due to

intussusception5 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

intussusceptionDate of op. 5-24-46

Autopsy results

PHYSICIAN: Please outline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

L. H. Hoyer MD

M. D. or other

Address

Long Md.Date signed 5-30-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1946

BUREAU V.S.

CERTIFICATE OF DEATH

★ 04432 4
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 hours 5 minutes
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 17 hours 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 300 Massachusetts Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Baby Girl Karns (Patricia Ann Karns)

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 18, 1946
 8. AGE: Years _____ Months _____ Days _____ It less than one day 17 hrs. 5 min.

9. Birthplace Cumberland, Maryland
 (Town, county, and state)
 10. Usual occupation Infant
 11. Industry or business
 12. Name William T. Karns
 13. Birthplace Maryland
 14. Maiden name Esther LaRiviere
 15. Birthplace Connecticut

16. Informant Memorial Hospital
 Address Cumberland, Maryland

17. Burial Date thereof May 20 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Greenmount Maus
 Location Cumberland, Md.

18. Funeral director Louis Steen Inc
 Address Cumberland, Md.

19. May 20, 19 46 J.P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 19 46 at 5:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 19 46 to May 18 19 46
 and that I last saw her alive on May 18 19 46

Immediate cause of death _____ DURATION _____

Premature (7 1/2) birth
Congenital Steleiosis
of lungs
 Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J.P. Franklin, M.D. M. D. or other

Address Cumberland, Md Date signed 5-20-46

RECEIVED

MAY 28 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-2

04433

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 81 yrs
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 721 Green St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Miss Katherine Keifer

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

8. (b) Name of husband or wife

8. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) March 15 1864

8. AGE: Years Months Days If less than one day
81 5 16 hrs. min.

9. Birthplace Maryland - Cumberland.
 (Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER 12. Name Spindler Keifer and
 13. Birthplace
 MOTHER 14. Maiden name Victoria Harter
 15. Birthplace Ind

16. Informant Bernadine Keifer
 Address 755 Green St.

17. Burial Date thereof May 3, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Peter's Paul, Cam.
 Location Cumberland

18. Funeral director Louis Steis Inc.
 Address Cumberland, Ind

19. May 7, 1946 J. P. Franklin M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 46, at 4:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
4-28-46 19 46, to 5-1-46 19 46
 and that I last saw him alive on 5-1-46 19 46

Immediate cause of death

Cerebral Apoplexy

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland Ind Date signed 5-1-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

04439

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

1 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 108 Columbia St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Kelly

3. (b) Social Security Number

217-10-1384

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 1, 1896

8. AGE:

50

Years

Months

Days

If less than one day

5

hrs.

min.

9. Birthplace

Vale Summit, Md.
(Town, county, and state)

10. Usual occupation

Dishwasher

11. Industry or business

Queen city Hotel

FATHER

12. Name

Henry Kelly

13. Birthplace

Md.

MOTHER

14. Maiden name

Bridget Kelly

15. Birthplace

Md.

16. Informant

Mrs. Bridget Kelly

Address

Cumberland Md.

17. (Burial, cremation, or removal) Which?

Burial

Date thereof

5/9/46
(month) (day) (year)

Cemetery or crematory

St Patrick

Location

Cumberland Md.

18. Funeral director

Louis Stern Inc.

Address

Cumberland Md.

19.

May 9, 1946J. P. Franklin, M.D.Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19 46, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/3/46 19 46, to 5/6/46 19 46and that I last saw him alive on 5/6/46 19 46

Immediate cause of death

acute atherosclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John R. Rozum M.D.

M. D. or other

Address Cumberland Md. Date signed 5/6/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

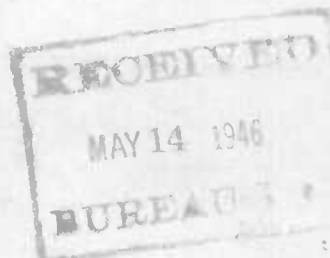
UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

1946

MAY 14 1946



ENCLOSURE

UNITED STATES DEPARTMENT OF JUSTICE



Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 04440

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs.
Hospital, institution, or street address where death occurred:
Potomac River
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 33 5th St.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Hester Wilburn Kenney

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife ✓

7. Birth date of deceased (mo., day, yr.) October 31, 1938 6. (c) If alive, give age 7 years

8. AGE: Years 7 Months 6 Days 14 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Pupil

11. Industry or business Public School

12. Name Marshall Kenney

13. Birthplace Wiley Ford, West Va.

14. Maiden name Bulah Wilburn

15. Birthplace Grantsville, Maryland

16. Informant Marshall Kenney

Address 33-5th St Cumberland, Maryland

17. Burial Date thereof May 19, 1946
(Burial, cremation, or removal. Which?) (Month) (Day) (Year)

Cemetery or crematory Zion Memorial Cemetery

Location Bedford Rd, Cumberland, Maryland

18. Funeral director John J. Auler

Address Cumberland Maryland

19. May 18, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about P.

20. DATE OF DEATH May 15th., 1946 at 12.30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Accidental drowning.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-15-46

Where did injury occur? Near Cumberland, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury drowning Injured at work? no

23. SIGNATURE James H. Brown, M.D.
M. D. or other

Address Cumberland, Maryland Date signed 5-16-46

Medical Examiner - Allegany Co

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V.S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

623 Columbia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 623 Columbia Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George W Kiiffner

3. (b) Social Security Number

705-09-9885

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Ella "Mabel" Kiiffner6. (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.)

June 18-1877

8. AGE:

Years

Months

Days

If less than one day

681018

hrs.

min.

9. Birthplace Cumberland Allegheny, Md.
(Town, county, and state)10. Usual occupation Retired - Hostler11. Industry or business BIO TR12. Name John Kiiffner13. Birthplace Germany14. Maiden name Elizabeth Hartung15. Birthplace Germany16. Informant Mrs. Ella KiiffnerAddress Cumberland, Md.17. Burial Date thereof May 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Trinity Lutheran CemeteryLocation Cumberland, Md.18. Funeral director John J. HoffnerAddress Cumberland, Md.19. May 8 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1946 at 12:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1946 to May 6, 1946and that I last saw him alive on May 5, 1946

Immediate cause of death

Myocarditis Chronic

DURATION

2 yrs.

Due to

Due to

Other conditions

BRONCHIAL ASTHMA6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mode of injury

Injured at work?

23. SIGNATURE

R. W. Stewaskis Jr. M.D.Address Cumberland, Md. Date signed May 7, 1946

RECEIVED

MAY 14 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

04442

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town Rural near Keyser, W. Va.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town rural near Keyser, W. Va.
(If outside city or town limits, write RURAL and give nearest town)Street No. R#3, Keyser, W. Va.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sallie Susan Kile

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Jacob H. Kile

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1873

8. AGE: Years Months Days If less than one day

73314

..... hrs. min.

8. Birthplace Pendleton Co. W. Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Alfred Kimble13. Birthplace Pendleton Co. W. Va.14. Maiden name Phoebe Shirk15. Birthplace Pendleton Co. W. Va.16. Informant Ona M. KileAddress R#3, Keyser, W. Va.17. Burial Date thereof June 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dawson CemeteryLocation Dawson, Md.18. Funeral director N.L. Rogers Funeral DirectorsAddress Keyser, W. Va.19. June 3, 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1946 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15, 1946 to May 31, 1946and that I last saw her alive on May 31, 1946

Immediate cause of death

Cardio-renal disease

DURATION

2 moDue to Arterio Sclerosis ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. Courrier, M.D.Address Keyser W. Va. Date signed 6/9/46

RECEIVED

JUN 6 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

04443

Reg. Dist. No. 9

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
12 Hill Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Allegany
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 12 Hill Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Margaret Katherine Klosterman

3. (b) Social Security Number

none

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... married
 6. (b) Name of husband or wife..... John Klosterman
 7. Birth date of deceased (mo., day, yr.)..... December 4, 1896 8. (c) If alive, give age..... 52 years
 8. AGE: Years..... 49 Months..... 5 Days..... 26 If less than one day..... hrs. min.

9. Birthplace..... Eckhart, Allegany, Md.
 (Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business..... home

12. Name..... John Labin

13. Birthplace..... Maryland

14. Maiden name..... Rebecca Folke

15. Birthplace..... Maryland

16. Informant..... John Klosterman

Address..... Frostburg, Md.

17. Burial..... Burial Date thereof..... June 3, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Michaels

Location..... Frostburg, Md.

18. Funeral director..... J. J. Oursst

Address..... Frostburg, Md.

19. (Date rec'd by registrar)..... 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 31 19..... 46, at..... 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 1940 19..... to..... May 31 19..... 46.

and that I last saw him..... alive on..... May 29 19..... 46.

Immediate cause of death..... hyperextension

Due to..... the myocardites

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....

23. SIGNATURE..... Wm. L. Lane, M.D.
 M. D. or other

Address..... Frostburg, Md. Date signed..... 6-1-46

8444

RECEIVED
JUN 5 1946
BUREAU V B

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County... Allegany
City or town... Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Days
Hospital, institution, or street address where death occurred:
Allegany Hospital, Cumberland, Maryland
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Illinois County... Winnnebago
City or town... Rockford
(If outside city or town limits, write RURAL and give nearest town)
Street No. 207 Victory Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Mary Kromholz

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mr. Edward Kromholz
8.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/24/1900
8. AGE: Years 46 Months 3 Days 16 If less than one day hrs. min.

9. Birthplace Freeport Illinois
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Frank Ocker

13. Birthplace Germany

14. Maiden name Katherine Vail

15. Birthplace Freeport Ill.,

16. Informant Edward J. Kromholz

Address 207 Victory St. Rockford Ill.,

17. Burial & removal Date there May 10 1946
(month) (day) (year)

Cemetery or crematory Galvary Cem.

Location Freeport Ill.,

18. Funeral director Louis Stein Inc.,

Address Cumberland Md.,

19. May 10, 1946 J. P. Franklin M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 1946 at 1:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 May 1946 to 10 May 1946

and that I last saw him alive on 9 May 1946

Immediate cause of death Carcinoma liver with metastases to brain, left axilla & rect.

Due to Cause unknown.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Dine M.D.

Address Cumberland, Md. Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1946
BUREAU V.I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County ALLEGANY

City or town FROSTBURG, rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. ROUTE 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BABY GIRL LAFFERTY

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

Single

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10, 1946

8. AGE: Years Months Days If less than one day
3 hrs. min.

9. Birthplace CUMBERLAND, MD., ALLEGANY
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name RAY LAFFERTY

13. Birthplace MD.

14. Maiden name MYRTLE PROPST

15. Birthplace W. VA.

18. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof May 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Eckhart Cem.

Location Eckhart, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. May 14, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13, 1946 at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 May 1946 to 13 May 1946
and that I last saw her alive on 13 May 46

Immediate cause of death

Crythoblastosis infantilis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Fuller B Whitworth M. D. or other

Address 112 Bedford St Date signed 12 May

RECEIVED

MAY 21 1946

BUREAU V.R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

04446

Reg. Dist. No. 4

DR. GRACIE

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 311 ARCH ST.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME VIRGINIA LAM
3.(b) Social Security Number None

4. Sex FEMALE
5. Color or race WHITE
6.(a) Single, married, widowed, or divorced SINGLE Divorced

6.(b) Name of husband or wife Fred Sweitzer
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) JAN. 2, 1909

8. AGE: Years 37 Months 3 Days 29 It less than one day _____ hrs. _____ min.

9. Birthplace MD. ALLEGANY CO.
(Town, county, and state)

10. Usual occupation SCHOOL TEACHER

11. Industry or business Public School

12. Name CHARLES LAM

13. Birthplace Elkton, VA.

14. Maiden name LELIA BENNETT

15. Birthplace VA. Shenandoah, Va.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4, 1946
(month) (day) (year)

Cemetery or crematory United Brethren Cemetery

Location Shenandoah, Virginia

18. Funeral director John J. Hefner

Address Cumberland, Md.

19. May 7 19 46 J. P. Rankin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 1 19 46 at 6:50A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 19 46, to May 1 19 46, and that I last saw him alive on April 30 19 46

Immediate cause of death Stroke

Due to Intestinal obstruction

Due to Tumor of large

Other conditions Correl. sigmoid carcinoma
Duration several months

(Include pregnancy within 8 months of death)
Major findings of operations Tumor of large gut
partial resection Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. G. Gracie, M.D. M. D. or other _____

Address Cumberland Date signed May 1-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1946
BUREAU V R

CERTIFICATE OF DEATH

★04447

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City near WESTERNPORT, rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. McCOOLE ROAD
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BABY BOY LAMBERT (PREMATURE)

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1946

8. AGE: Years Months Days It less than one day
2 hrs. 5 min.

9. Birthplace WESTERNPORT, MARYLAND
(Town, county, and state)

10. Usual occupation PREMATURE

11. Industry or business

12. Name Esley Francis Lambert

13. Birthplace Westernport, Maryland

14. Maiden name Ethel Jesse Hudson

15. Birthplace Westernport, Maryland

16. Informant Father: E. Francis Lambert

Address Route #3, Box 29, Westernport, Md.

17. Burial Date thereof May 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bloomington Cem

Location Bloomington, Md.

18. Funeral director Father: E. Francis Lambert

Address Near Westernport, Md.

19. May 21, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 20, 1946 at 7:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h..... alive on 19

Immediate cause of death

DURATION

5 mon. Fetus

Due to (Premature)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Esley J. Lambert

23. SIGNATURE Cumberland M. D. or other

Address May 22, '46 Date signed

MARGIN RESERVED FOR BINDING

I

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

717

RECEIVED

MAY 28 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 04448 4

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

549 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Allegany

City or town... Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 549 Greene St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harmon G. Lehman

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Flora C. Baer

6. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1860

8. AGE: Years 86 Months 1 Days 26 It less than one day hrs. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Retired Cobbler

11. Industry or business Cobbler

12. Name William Lehman

13. Birthplace Germany

14. Maiden name Wilhemie Butt

15. Birthplace Germany

16. Informant Mrs. Flora C. Lehman

Address 549 Greene St. Cumberland, Md.

17. Burial Date thereof May 18, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. May 18 1946 Joseph O. Franklin M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1946 at 3:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1946 to May 15 1946

and that I last saw him alive on May 15 1946

Immediate cause of death

Crown of Thrombosis

Due to

Generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address 41 Greene St. Cumberland, Md.

Date signed May 17 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V. S.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Shades Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. Shades Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Teresa L. "Lehman" Lindner

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John H. Lindner

7. Birth date of deceased (mo., day, yr.)

August 24, 18866. (c) If alive, give age 59 years

8. AGE:

Years

Months

Days

If less than one day

0991

hrs.

min.

9. Birthplace

Cumberland Allegheny, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name

Espy A. Lehman

13. Birthplace

Penn.

MOTHER

14. Maiden name

Elizabeth Mc Mahay

15. Birthplace

Penn.

16. Informant

John H. Lindner

Address

Cumberland, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 28, 1946
(month) (day) (year)

Cemetery or crematory

St. Peter & Pauls Cemetery

Location

Cumberland, Md.

18. Funeral director

J. P. Hankin, M.D.

Address

Cumberland, Md.

19.

May 27, 1946
(Date rec'd by registrar)

19.

J. P. Hankin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1946 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-19-1946 to 5-25-1946and that I last saw her alive on May 25, 1946

Immediate cause of death

Carcinoma of gall bladder and pancreas

DURATION

6 Mo.

Due to

Carcinomatosis1 Mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland, Md. Date signed 5-27-46

RECEIVED

JUN 4 1946

BUREAU V 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4697

CERTIFICATE OF DEATH

04450 4
Reg. Dist. No.

1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANYCity or town... Westernport
(If outside city or town limits, write RURAL and give nearest town)Street No. WESTERNPORT, MD.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

LOCHNER, AUGUST MR.

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

MARTHA Storey Lochner

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

February 9, 1875

8. AGE:

Years

Months

Days

If less than one day

71227

hrs.

min.

9. Birthplace

MD. Lonaconing, Allegany County
(Town, county, and state)

10. Usual occupation

JANITOR @ REDMAN CLUB

11. Industry or business

FATHER

12. Name

LOCHNER, JOHN

13. Birthplace

Germany

MOTHER

14. Maiden name

FRATZ, MARY

15. Birthplace

Bercoing, Maryland

16. Informant

Address

Mrs. Helmut Baird
Pittsburgh, Pennsylvania

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

May 9, 1946
(month) (day) (year)

Cemetery or crematory

Oak Hill Cem.

Location

Lonaconing, Md.

18. Funeral director

Address

M. Eichhorn
Lonaconing, Md.

19. May 8, 1946

(Date rec'd by registrar)

J. L. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 6, 19 46, at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-2819 46 to5-619 46

and that I last saw him alive on

5-619 46

Immediate cause of death

Cancer of the
pancreas

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Cancer of the pancreas
& metastases Date of op. 5-4-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. B. Jones M.D.

D. or other

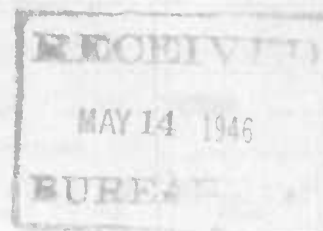
Address

Medical BldgDate signed 5-7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

04451 4
Reg. Dist. No.

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
5 Marion Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5 Marion Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

GEORGE W. LOWERY

3. (b) Social Security Number

214-05-8484

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Lula Geisbert
6. (c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) April 21, 1888
8. AGE: Years 58 Months 0 Days 16 If less than one day
.....hrs.min.

9. Birthplace Hyndman, Pa. Pa.
(Town, county, and state)
10. Usual occupation Pipefitter
11. Industry or business B. & O. R. R.
12. Name Jacob Lowery
13. Birthplace Hyndman, Pa.
14. Maiden name Mary Frances Deneen
15. Birthplace Hyndman, Pa.

16. Informant Mrs. Lula Lowery
Address 5 Marion Street, Cumberland, Md.
17. Burial Date thereof May 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Meyersdale, Pa.
18. Funeral director William H. Kight
Address Cumberland, Md.

19. May 8, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1946 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1946 to May 7, 1946
and that I last saw him alive on May 6, 1946

Immediate cause of death Coronary Occlusion DURATION 1 week

Due to

Due to

Other conditions Asthma-bronchial 40 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Swastis, Jr. M.D. M. D. or other

Address Cumberland Md Date signed 5/8/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04452

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY
City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 61 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MARYLAND County... ALLEGANY
City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 220 HARRISON ST.
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

MRS. ANITA LYNCH

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife HORACE LYNCH
8.(c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.) FEB. 4, 1907
8. AGE: Years 39 Months 3 Days 9 If less than one day
..... hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13, 1946 19... 11:30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
MAR. 13, 1946 19... to MAY 13, 1946 19...
and that I last saw h er alive on MAY 13, 1946
Immediate cause of death
CARDIAC FAILURE
Due to CARCINOMATOSIS
GENERALIZED
Due to PRIMARY CARCINOMA
CERVIX
Other conditions
(Include pregnancy within 3 months of death)

DURATION

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
12. Name SILAS DETWILER
13. Birthplace PENNA.
14. Maiden name MARY HOOK
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) May 16, 1946
(month) (day) (year)
Cemetery or crematory Alto Rest Cemetery
Location Holidaysburg, Blair, Pa.
18. Funeral director William H. Kight
Address Cumberland, Md.

19. May 14, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fuller B Whitworth M. D. or other
Address 112 Bedford St. Date signed 13 May 46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

04453

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 hrs. 25 min.

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 25 hrs. 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Little Orleans
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(c) If veteran, name war _____

3. (a) FULL NAME

Homer Mann

3. (b) Social Security Number

217-10-6957

4. Sex

Male

5. Color or race

White Married

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Irene Price Mann6. (c) If alive, give age 32 years7. Birth date of deceased (mo., day, yr.) March 1, 19108. AGE: Years 36 Months 2 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace McKeesport, Allegheny Co., Pa.
(Town, county, and state)10. Usual occupation Clerk & Air plane Mechanic

11. Industry or business _____

12. Name Scott M. Mann13. Birthplace Washington Co., Md.14. Maiden name Edith V. Creek15. Birthplace Allegheny Co., Md.16. Informant Mrs. Irene P. MannAddress Little Orleans, Md.17. Burial Date thereof May 7, 1946
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Piney Plains Meth. ChurchLocation Piney Plains, Md.18. Funeral director Charles R. BastAddress Hancock Md.19. May 7, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH May 4th., 1946 19____ at 9.25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

Extensive second and third degree burns of head, face, DURATION 25 hrs., 25 min.Due to neck, trunk and extremities.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results no autopsy

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-3-46Where did injury occur? Belle Grove, Allegheny, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) highwayMeans of injury coll. of truck and auto Injured at work? no23. SIGNATURE Russell H. Johnson, M.D.
M. D. or other 5-5-46Address Cumberland, Maryland. Date signed _____

Deputy Medical Examiner - Allegheny Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1946
BUREAU V S

Within corporate limits
DR. SCHINDLER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

Reg. Dist. No. 04454 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 24 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 404 DECATUR ST.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

R. HUGH McCLEAVE

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE
6. (b) Name of husband or wife
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) OCTOBER 25, 1860
8. AGE: Years 85 Months 5 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)
10. Usual occupation RETIRED ATTORNEY
11. Industry or business
12. Name ROBERT McCLEAVE
13. Birthplace VIRGINIA
14. Maiden name Sarah Ann WILKINSON
15. Birthplace VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial Date thereof May 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. May 10, 1946 Registrar J. P. Franklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 8, 1946 11:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
_____ 19 _____, to MAY 8, 1946
and that I last saw him alive on May 8, 1946

Immediate cause of death Pericarditis - Pericarditis DURATION 2 days

Due to Hypertension C.V. and years
Due to pericarditis

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Blane M. Schindler M. D. or other
Address 41 Greenfield Date signed May 9, 1946
Cumberland, Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
MAY 11 1946
BUREAU V

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-d

04455

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Near Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
R.F.D. #2 Williams Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #2 Williams Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Dennis Grady Mc Culley

3. (b) Social Security Number

220-10-9025

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Emerson E. Ireland

6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) June 28 1876

8. AGE: Years 69 Months 10 Days 29 hrs. min.

9. Birthplace Oldtown Ind.
(Town, county, and state)

10. Usual occupation Employee Blair's Lbr.

11. Industry or business Machining viler

12. Name John Mc Culley

13. Birthplace Ind.

14. Maiden name Susan Ireland

15. Birthplace W.Va.

16. Informant Ans Dennis G. Mc Culley

Address R.F.D. #2 Williams Rd.

17. Burial Date thereof May 31 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. May 31 19 46 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to May 27 1946

and that I last saw him alive on May 26 1946

Immediate cause of death

Malignant tumor registering

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. S. Johnson M.D.

Address Cumberland, Md. Date signed 5-28-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

32

CERTIFICATE OF DEATH

04456

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Mr. George McDonald

3.(b) Social Security Number

213-09-9515

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteMarried6.(b) Name of husband or wife Irma Athey McDonaldB.(c) If alive, give age 42 years7. Birth date of deceased (mo., day, yr.) April 23, 18848. AGE: Years Months Days If less than one day
62 0 26 hrs. min.9. Birthplace Maryland, Barton Allegany Co.
(Town, county, and state)10. Usual occupation Coal Miner11. Industry or business Naval ArsenalFATHER 12. Name John James McDonald13. Birthplace ScotlandMOTHER 14. Maiden name Sarah Ann Davis15. Birthplace Barton, Maryland16. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial (Burial, cremation, or removal. Which?) May 22, 1946
(month) (day) (year)Cemetery or cremator Laurel Hill CemLocation Moscow, Md.18. Funeral director Ellsworth S. BoalAddress Westernport Md.19. May 20, 1946 J. P. Fankhui, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 19 46 at 11:20A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 1946 to May 19, 1946
and that I last saw him alive on May 19, 1946Immediate cause of death Coronary Thrombosis - chr. DURATIONDue to AsthmaDue to BronchiectasisOther conditions Chronic Myocarditis Duration: Unknown(Include pregnancy within 3 months of death) None

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Clayton Furrer M.D. other _____Address Cumberland Date signed May 19, 1946

RECEIVED

MAY 28 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

04457

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

Four days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett Co.City or town Deer Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 5 mi North Deer Park, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mose C. Miller

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Anna Mae (O'Brien)Miller

6.(c) If alive, given age years

7. Birth date of

deceased (mo., day, yr.)

January 5, 1885

8. AGE:

61

Yrs

Months

Days

If less than one day

329

hrs.

min.

9. Birthplace

Allegany Co., Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 19 46 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/28 19 46 to 5/3 19 46and that I last saw him alive on 5/3/46 19

Immediate cause of death

ca of ischemia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

ca of ischemia Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Rozum M. D. or otherAddress Garrettsburg, Md. Date signed 5/4/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED
MAY 14 1946
BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

04458

8

Reg. Dist. No.

FILM No. I O 4 MAY 14 1946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County AlleganyCity or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Douglas Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)Street No. Douglas Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Hall Mitchell

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Robert F. Mitchell8. (c) If alive, give age 82 years7. Birth date of deceased (mo., day, yr.) 16 November 18688. AGE: Years Months Days If less than one day
77 78 5 19 hrs. min.9. Birthplace Barchine-Lancastershire-Scotland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Robert Spierr13. Birthplace Scotland14. Maiden name Ann Robertson15. Birthplace Scotland16. Informant George MitchellAddress Pittsburgh, Penna17. Burial Date thereof 8 May 1946
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Lonaconing, Md.18. Funeral director Ellsworth S. BoalAddress 111 Church St, Westernport, Md19. May 6 1946 Dr. E. O. G. G.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 May 19 46 3:30p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Thoburn 19 45 to May 5 19 46
and that I last saw on alive on May 5 19 46

Immediate cause of death

Coronary occlusion

DURATION

Due to Arterio Sclerosis 3 mo

Due to

Other conditions Major Pelvic 6 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. E. O. G. G. M.D. or otherAddress Lonaconing Date signed May 5 1946

REC

MAY 9 1946

BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

04459

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. Bowery Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wm. Carey Morgan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

none

7. Birth date of

deceased (mo., day, yr.)

August 31, 1870

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

75826

hrs.

min.

9. Birthplace

Frostburg Md.
(Town, county, and state)

10. Usual occupation

Retired miner

11. Industry or business

Coal mining

FATHER

12. Name

Henry Morgan

MOTHER

13. Birthplace

England

14. Maiden name

Mary A. Henry

15. Birthplace

Wales

16. Informant

James A. Morgan

Address

Carlos, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 29, 1946
(month) (day) (year)

Cemetery or crematory

Allegany

Location

Frostburg Md.

18. Funeral director

J. R. Durbin

Address

Frostburg Md.

19.

(Date rec'd by registrar)

19

5-28 46 Mrs. Nancy H. De
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 19 46 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 15 19 46 to May 27 19 46and that I last saw him alive on May 27 19 46

Immediate cause of death

arterio-sclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. C. Diehl, M.D.
M. D. or other

Address

Frostburg, Md.Date signed 5/28/46

RECEIVED

MAY 30 1946

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ma*

CERTIFICATE OF DEATH

B. Diehl
 04460 9
 Reg. Dist. No.

1. PLACE OF DEATH:

 County *Allegany*
 City or town *Frostburg*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

*84**2**18*

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 2

19

46

at

5 P.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 *45* to *May 2* 19 *46*and that I last saw h. *pm* alive on *May 2* 19 *46*

Immediate cause of death

arterio. sclerosis

DURATION

Due to

Due to

Other conditions

*Fracture of femur**due to* *accidental fall* *Causes*

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *July 27th, 1945*Where did injury occur? *Frostburg, Allegany* *Maryland*

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *home of friends*Means of injury *Accidental fall* Injured at work?

23. SIGNATURE

J. C. Diehl, M.D. M. D. or otherAddress *Frostburg, Md.* Date signed *5/6/46*

RECEIVED
MAY 9 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: County... <u>Allegany</u> City or town... <u>Frostburg</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: <u>Miners Hospital</u> How long in hospital or institution? <u>3 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Maryland</u> County... <u>Allegany</u> City or town... <u>Frostburg</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Main St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Lillian Anita O'Rourke</u>				3. (b) Social Security Number <u>212-01-7488</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Single</u>			
B. (b) Name of husband or wife				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>June 27, 1903</u>				8. AGE: Years <u>42</u> Months <u>10</u> Days <u>5</u> If less than one day hrs. min.			
9. Birthplace <u>Midland Allegany, Md.</u> (Town, county, and state)				10. Usual occupation <u>clerk</u>			
11. Industry or business <u>J. C. Murphy Co.</u>				12. Name <u>Hugh O'Rourke</u>			
13. Birthplace <u>unknown</u>				14. Maiden name <u>Marian Willison</u>			
15. Birthplace <u>Scotland</u>				16. Informant <u>Mrs. Aurea Fleigle</u> Address <u>Cumberland Md.</u>			
17. Burial (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>May 6, 1946</u> (month) (day) (year) Cemetery or crematory <u>Eckhart Cemetery</u> <u>Eckhart Md.</u> Location				18. Funeral director <u>J. J. Quist</u> Address <u>Frostburg Md.</u>			
19. 5-6 (Date rec'd by registrar)				46 Mrs. Nancy A. De Registrar			

MEDICAL CERTIFICATION 20. DATE OF DEATH <u>May 4</u> 19 <u>46</u> at <u>2:4</u> M		<u>30</u>
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Apr 29</u> 19 <u>46</u> to <u>May 4</u> 19 <u>46</u> and that I last saw him alive on <u>May 3</u> 19 <u>46</u>		
Immediate cause of death <u>Broncho Pneumonia</u>		DURATION <u>2 Days</u>
Due to <u>acute Bronchial</u>		<u>2 wks</u>
Due to <u>Asthma</u>		
Other conditions		
(Include pregnancy within 3 months of death)		
Major findings of operations		
Antopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.		
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work?.....		
23. SIGNATURE <u>W. M. Landrum</u> M. D. or other Address <u>Frostburg Md.</u> Date signed <u>5-6-46</u>		

RECEIVED
MAY 9 1946
BUREAU V.E.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death.....15 days
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?.....15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....W. VA. County.....MINERAL
 City or town.....NEW CREEK
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

LESTER K. PANCAKE

3. (b) Social Security Number

None

4. Sex.....MALE 5. Color or race.....WHITE 6. (a) Single, married, widowed, or divorced.....MARRIED

8. (b) Name of husband or wife.....FREDA DELLINGERB. (c) If alive, give age.....42 years7. Birth date of deceased (mo., day, yr.).....JANUARY 21, 1898

8. AGE: Years.....48 Months.....3 Days.....22 If less than one day..... hrs..... min.....

9. Birthplace.....New Creek, Mineral County, W. Va.
(Town, county, and state)10. Usual occupation.....COAL DEALER

11. Industry or business

12. Name.....ANDREW PANCAKE13. Birthplace.....Hampshire County, W. Va.14. Maiden name.....EMMA ROBEY15. Birthplace.....Hampshire County, W. Va.18. Informant.....Memorial Hosp.Address.....Cumberland, Md.17. Burial..... Date thereon.....May 16, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....Queen's Point CemLocation.....Kepler, W. Va.18. Funeral director.....WalkerAddress.....Kepler, W. Va.19. May 14, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....MAY 13 1946 at 6:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 28 1946 to May 13 1946and that I last saw him alive on May 13 1946Immediate cause of death.....acute myocardial infarctionDue to.....Ch. MyocarditisDue to.....Ch. CholelithiasisOther conditions.....Cholelithiasis

(Include pregnancy within 3 months of death)

Major findings of operations.....Ch. CholelithiasisDate of op.....5-7-46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....J. P. Franklin M. D. or otherAddress.....Cumberland, Md. Date signed.....5-13-46

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

RE: [illegible]

RECEIVED
MAY 21 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

★ 04463 4
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
708 Lafayette Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 708 Lafayette Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Viola Beatrice Powell

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

Dennis J. Powell

7. Birth date of deceased (mo., day, yr.)

Feb 23, 1887

6. (c) If alive, give age years

8. AGE:

Years 59 Months 3 Days 12
 If less than one day hrs. min.

9. Birthplace

Cumberland Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Hookabough

13. Birthplace

Md.

MOTHER

14. Maiden name

Mary Henck

15. Birthplace

Md.

16. Informant

Dennis J. Powell

Address

Cumberland Md.

17.

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Burial
Willcrest

Date thereof

May 4, 1946
(month) (day) (year)

Location

Cumberland Md.

18. Funeral director

Louis Stein Inc.

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

May 4, 1946
J.P. Franklin M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 1st19 46, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 - 46 1946, to May 1 - 46 1946
 and that I last saw h. in alive on May 1st 46 1946

Immediate cause of death

Uremic Coma

DURATION

36 hrs

Due to

Cardio Renal disease8 mos

Due to

Paraneoplastic NephritisWhen

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

None

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Means of Injury

23. SIGNATURE

J.H. Matthew M.D.
M. D. or other

Address

101 S. Centre St.Date signed 5/2/46

RECEIVED
MAY 7 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04464

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred

113 Harrison St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 113 Harrison St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

James William Reynolds

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Anna Gordon

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 67 Months 9 Days 16 If less than one day9. Birthplace Cumberland, Maryland
(Town, county, and state)10. Usual occupation Steward11. Industry or business Forty & Eight Club12. Name Z.T. Reynolds13. Birthplace Ind.14. Maiden name Mary Gist15. Birthplace Ind.16. Informant Mrs. Anne ReynoldsAddress 113 Harrison St.17. Burial
(Burial, cremation, or removal. Which?)Date thereof June 3, 1946
(month) (day) (year)Cemetery or crematory St. Patrick,Location Cumberland Md.18. Funeral director Louis Stein Inc.Address Cumberland19. June 3, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 at 4:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-46 to 5-31-46and that I last saw him alive on 5-31-46

Immediate cause of death

Cerebral apoplexy

DURATION

3 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland Date signed June 1-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

CERTIFICATE OF DEATH

04465

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
 City or town Maracoring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred: Scratch Hill
 How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Maracoring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Scratch Hill
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Walter Dent Richter

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Annie Clarkson Richter
 6. (c) If alive, give age L years
 7. Birth date of deceased (mo., day, yr.) May 1, 1869

8. AGE: Years 77 Months 7 Days 8 It less than one day
 hrs. min.

9. Birthplace Newburgh, N. Va.
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Own Business

12. Name Frederick Richter

13. Birthplace Newburgh, N. Va.

14. Maiden name Elizabeth Hunt

15. Birthplace Preston Co., N. Va.

16. Informant Mrs. John Patton

Address Maracoring, Md.

17. Burial Date thereof May 12, 1946
 (Burial, cremation, or removal) (Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Chrostburg, Md.

18. Funeral director M. Eichhorn

Address Maracoring, Md.

19. May 10 1946 Dr. E. Donoghue
 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1946 to May 1946
 and that I last saw him alive on May 8 1946

Immediate cause of death Cerebral Hemorrhage

Due to arteriosclerosis

Due to advanced

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. E. Donoghue M. D. or other

Address Maracoring, Md. Date signed 5/10/46

RECEIVED

MAY 13 1946

BUREAU V E

DR. R. WILLIAMS

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County Morgan
 City or town ORLEANS CROSS ROADS
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MRS. LENA, L. ROBEY

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED

6. (b) Name of husband or wife GEORGE H. ROBEY7. Birth date of deceased (mo., day, yr.) OCT. 11 1901 8. (c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
44 7 11 hrs. min.9. Birthplace MARYLAND
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name WILLIAM HENRY HINER13. Birthplace PENNSYLVANIA14. Maiden name SOMIE KNIPPLE15. Birthplace PENNSYLVANIA16. Informant H. LEE HINERAddress CUMBERLAND, MD.17. Burial Date thereof May 25 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose HillLocation Cumberland, Md18. Funeral director Louis Stein Inc.Address Cumberland, Md.19. May 24 19 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 22 19 46 at 6:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/1/46 19 46 to 5/22/46 19 46
and that I last saw him/her alive on 5/21/46 19 46

Immediate cause of death

Coronary ThrombosisDue to Coronary Sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE R. Williams, M.D. M. D. or otherAddress Medical Bldg. Date signed 5/22/46

RECEIVED

MAY 28 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

1454
CERTIFICATE OF DEATH04467 4
Reg. Diat. No.

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 Years
 Hospital, institution, or street address where death occurred:
23. Bedford St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 23. Bedford St
 (If rural, give LOCATION)
 2.(d) If veteran, name war

3. (a) FULL NAME

JOHN HENRY ROBINETTE

3. (b) Social Security Number

219-14-6967

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ida B. Robinette

8. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.)

May 5, 1871

8. AGE:

75

Years

Months

0

Days

20

If less than one day

hrs.

min.

9. Birthplace

Des Moines, Iowa

(Town, county, and state)

10. Usual occupation

Paperhanger

11. Industry or business

Hanging Paper

FATHER

12. Name

Jermiah W. Robinette

13. Birthplace

Unknown

MOTHER

14. Maiden name

Lucelle Long

15. Birthplace

Unknown

16. Informant

Mrs. Ruth Hess

Address

23 Bedford St. Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 28, 1946
(month) (day) (year)

Cemetery or crematory

Duling Cemetery

Location

Keyser, Mineral, West Virginia

18. Funeral director

William H. Kight

Address

Cumberland, Maryland

19.

May 28, 1946
(Date rec'd by registrar)J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

25 MAY

1946, at 4:04 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 April

1946, to 25 May

1946

and that I last saw him alive on 25 May 1946

Immediate cause of death

myocarditis Chronic +
 Hemiplegia left. Complete
 Due to Hypertension - Arteriosclerosis.
 Generalized Severe

DURATION

Due to

Other conditions

Bilateral Indirect Inguinal
 Hernias (massive) Incarcerated.
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin, M.D.

M. D. or other

Address

112 Bedford St

Date signed

28 May 46

RECEIVED

JUN 4 1946

BUREAU V.S.

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Crunkland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address, where death occurred:
521 Overath Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
State Maryland County Allegheny
City or town Crunkland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 521 Overath Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary C Rose

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife C Rose Rose
7. Birth date of deceased (mo., day, yr.) Nov 18 1871 6.(c) If alive, give age _____ years
8. AGE: Years 25 Months 1 Days 27 It less than one day _____ hrs. _____ min.

9. Birthplace Bedford Co. Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name Richard Humming
13. Birthplace Pa.
14. Maiden name Sophia Price
15. Birthplace Pa.

16. Informant Pearl J Clayton
Address 521 Overath Ave Crunkland
17. Burial Date thereof May 20 '46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory St Peter & Pauls Cem.
Location Crunkland
18. Funeral director Arms Stein & Son
Address Crunkland
19. May 20 1946 J P Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1946 at 3:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1920 to May 17 1946
and that I last saw him alive on May 14 1946
Immediate cause of death coronary heart failure
DURATION 2 years
Due to Arteriosclerosis 3 years
Due to _____
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE L. P. Franklin M.D.
Address Long Ma M. D. or other _____
Date signed 5-20-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. HAWKINS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04469

CERTIFICATE OF DEATH

Reg. Dist. No. 166 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 17 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETTCity or town FRIENDSVILLE, MD.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

MRS. IVA RUSH

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED6.(b) Name of husband or wife ASA RUSH

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

OCTOBER 91894

8. AGE:

Years

Months

Days

If less than one day

51

_____ hrs. _____ min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

MOTHER FATHER

12. Name CORNELIUS W. FRIEND13. Birthplace MARYLAND14. Maiden name MAY FRIEND15. Birthplace MARYLAND

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17.

(Burial, cremation, or removal, which?)

Date thereof

5 7-46
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 57 1/2
(Date rec'd by registrar)19. 46Julius Rowan
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 5, 1946 @ 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

APRIL 18,1946,to MAY 5,1946

and that I last saw him/her alive on

MAY 5, 1946

Immediate cause of death

Generalized peritonitis

DURATION

10 d.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED

MAY 15 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-1)

CERTIFICATE OF DEATH

04470

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
City or town Franklin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 years
Hospital, institution, or street address where death occurred.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Franklin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mary D. Hughes Salisbury

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Albert F. Salisbury 6. (c) If alive, give age 2 years
7. Birth date of deceased (mo., day, yr.) October 8, 1858
8. AGE: Years 87 Months 6 Days 27 If less than one day
hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1946 at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1946 to May 5 1946
and that I last saw him alive on May 1 1946
Immediate cause of death Myocardial infarction
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

9. Birthplace Hawkins, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
12. Name Henry Hughes
13. Birthplace unknown
14. Maiden name Sara Lease
15. Birthplace unknown
16. Informant William Murray
Address Coyser, Rt. 1, W.V.
17. Burial Date thereof May 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Hill Cemetery
Location Franklin, Md.
18. Funeral director Mr. Bachman
Address Franklin, Md.
19. May 7 1946 Dr. E. D. F. Johnson
(Date read by registrar) Registrar

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, term, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Henry D. Hays M. D. or other
Address Franklin, Md. Date signed May 7 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED
MAY 9 1946
BUREAU V. E.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, MarylandHow long in hospital or institution? 4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. 219 Paca St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Ida Simpson

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Mr. Charles Simpson

8.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

June 20, 1876

8. AGE:

69

Years

Months

10

Days

18

If less than one day

hrs.

min.

9. Birthplace

Patterson Creek, W. Va.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Jonathon Anderson

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Mary

15. Birthplace

W. Va.

18. Informant

Mr. Charles SimpsonAddress 219 Paca St. Cumberland, Md.

17.

(Burial, cremation, or removal, Which?)

BurialDate thereof May 11, 1946
(month) (day) (year)

Cemetery or crematory

Mt. Zion Cem.

Location

Near Patterson Creek, W. Va.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

May 11, 1946 J. P. Franklin M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 19 46 at 5:16 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 8 19 46 to May 8 19 46
and that I last saw her alive on May 8 19 46

Immediate cause of death

Cerebral Vascular Accident

DURATION

1 day

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Arthur T. Jones M.D.

M. D. or other

Address

160 S. Centre St.Date signed 5-10-46

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED

MAY 14 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

04472

★ Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Alleg. Monaca Hospital
 City or town... Frostburg Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... AlleganyCity or town... Donacoring

(If outside city or town limits, write RURAL and give nearest town)

Street No. State Station Run

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

5. Color or race

8. (d) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

46 Mrs. X... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

Address

CERTIFICATE OF DEATH

101

RECEIVED

RECEIVED

RECEIVED
MAY 9 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

04473

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
529 Furnace St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 529 Furnace St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

MARGARET WALKER SOMMERVILLE

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Douglas Sommerville

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1867

8. AGE: Year 78 Months 7 Days 3 If less than one day hrs. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Alexander Walker

13. Birthplace Scotland

14. Maiden name Jeanie Caldwell

15. Birthplace Scotland

16. Informant Mrs. Oliver W. Diehl

Address Route 3, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1946
(month) (day) (year)

Cemetery or crematory Zion Memorial Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. May 14, 1946 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1946 at 11-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22, 1946 to May 12, 1946 and that I last saw him alive on May 12, 1946

Immediate cause of death

Diabetic Nucleosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. H. Walker M. D. or other

Address 49 Green St Date signed 5-13-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04474

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleganyCity Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. RT. 2, Williams Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

John Andrew Stegmaier

3. (b) Social Security Number

None4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Annie Dettmer Stegmaier6.(c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) Sept 14, 18708. AGE: Years 75 Months 8 Days 6 If less than one day
..... hrs. min.9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)10. Usual occupation Farming11. Industry or business Own farm12. Name Leonard Stegmaier13. Birthplace Germany14. Maiden name Gertrude Heck15. Birthplace Greenspring, W. Va.16. Informant Theodore StegmaierAddress RT 4, Cumberland, Md.17. Burial Date thereof May 23, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter & Paul's CemeteryLocation Cumberland, Md.18. Funeral director John J. HoferAddress Cumberland, Md.19. May 23, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1946 at 6:48 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5-15-46 to 5-20-46and that I last saw him alive on 5-20-46Immediate cause of death MyocarditisDURATION
5 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE J. P. Johnson, M.D.
M. D. or otherAddress Cumberland, Md. Date signed 5-22-46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1946

BUREAU V.S.

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

044754
Reg. Dist. No.

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

1 HOUR 30 MIN.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County BEDFORDCity or town HYNDMAN
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

BABY BOY THOMAS (PREMATURE INFANT)

3. (b) Social Security Number

None4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced INFANT

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) MAY 2, 19468. AGE: Years _____ Months _____ Days _____ If less than one day
1 hrs. 30 min.9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name MARSHALL H. THOMAS13. Birthplace PENNSYLVANIA14. Maiden name MARY PRICE15. Birthplace PENNSYLVANIA16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof May 3, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hyndman CemLocation Hyndman, Penna18. Funeral director Harvey N. ZuglerAddress Hyndman, Penna.19. May 3 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 2, 1946 1946 at 2:05 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 2 1946 to May 2 1946
and that I last saw h. live on May 2 1946Immediate cause of death Premature
6 mo. gestation

DURATION

2 hrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John A. Topper MD M. D. or otherAddress Hyndman Pa Date signed 5-3-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

04476

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital
How long in hospital or institution 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Corriganville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Griffith Thomas

3. (b) Social Security Number

214-05-8827

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Annie Muer Thomas7. Birth date of deceased (mo., day, yr.) 4/19/18956. (c) If alive, give age 50 years8. AGE: Years Months Days It less than one day
51 1 4 _____ hrs. _____ min.9. Birthplace Foxburg Md
(Town, county, and state)10. Usual occupation Bar tender

11. Industry or business

12. Name James Thomas
13. Birthplace Md.14. Maiden name Evelyn A Phillips15. Birthplace Md16. Informant Mrs. Annie ThomasAddress Corriganville Md17. Buried Date thereof May 17 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BellevueLocation Chamberland Md18. Funeral director Harvey H. FeiglerAddress Hyndman Pa19. May 17 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1946 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1942 to May 1946
and that I last saw him alive on May 13 1946Immediate cause of death Chronic Cardio-
vascular Heart
Disease

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John H. Topper
M. D. or other _____Address Hyndman Pa Date signed 5.15.46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1946

BUREAU V.S.

Within corporate limits

Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B32)

04434

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, institution, or street address where death occurred:
Allegany County Infirmary
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 914 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
James Thomas

3. (b) Social Security Number
None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Annie Askey Thomas

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) March 14, 1873

8. AGE: Years 73 Months 1 Days 24 If less than one day
..... hrs. min.

9. Birthplace Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation Retired car repairman

11. Industry or business B&O RTR

12. Name Harry Thomas

13. Birthplace England

14. Maiden name Caroline Edwards

15. Birthplace England

16. Informant Mrs. Irma South

Address Hagerstown, Md.

17. Burial Date thereof May 10, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart, Md.

18. Funeral director John J. Hoyer

Address Cumberland, Md.

19. May 9 1946
(Date rec'd by registrar)

J. B. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1946 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 5-3- 1946 to 5-8- 1946

and that I last saw him/her on 5-8- 1946

Immediate cause of death

Cardiovascular

Due to renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE J. F. Williams M. D. or other

Address Cumberland Date signed 5-8-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1946

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04435

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Franklin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 monthsHospital, institution, or street address where death occurred: Allegany County InfirmaryHow long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleganyCity or town Franklin
(If outside city or town limits, write RURAL and give nearest town)Street No. 104 Franklin
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Turner Jr.

3. (b) Social Security Number

220-10-43304. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married8.(b) Name of husband or wife Sarah W. Walker7. Birth date of deceased (mo., day, yr.) July 11 - 1868 8.(c) If alive, give age 77 years8. AGE: Years 77 Months 10 Days 10 If less than one day

hrs. min.

9. Birthplace Scotland
(Town, county, and state)10. Usual occupation Retired Painter11. Industry or business Celanese Corp.12. Name James Turner13. Birthplace Scotland14. Maiden name Agnes Scott15. Birthplace Scotland16. Informant Mrs. George BuchananAddress 138 Bondary St. Franklin17. Burial Date thereof 5-25-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AlleganyLocation Franklin18. Funeral director Jacob WagnerAddress Franklin, MD19. May 25, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22-1946 at 5:10 P.M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 5-10-1946 to 5-22-1946 and that I last saw him alive on 5-21-1946

Immediate cause of death

DURATION

Broncho pneumoniaDue to Infirmitiesof age.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. WilliamsAddress Cumtland Date signed 4-25-46

RECEIVED

MAY 28 1946

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of usual residence of deceased is shown on Film No. 106 - 7/24/46

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore *ED*

CERTIFICATE OF DEATH

04436

10

Reg. Dist. No.

1. PLACE OF DEATH:

County... *Allegheny*
City or town... *Mt. Savage*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *47 years*
Hospital, institution, or street address where death occurred:
Mt. Savage
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland* County... *Allegheny*
City or town... *Mt. Savage*
(If outside city or town limits, write RURAL and give nearest town)
Street No... *Church Hill*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME*Harold Leslie Uhl***3. (b) Social Security Number***none*

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Single*
6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *January 23, 1899* 6.(c) If alive, give age

8. AGE: Years *47* Months *3* Days *14* If less than one day

9. Birthplace... *Mt. Savage*
(Town, county, and state)

10. Usual occupation... *None*

11. Industry or business... *None*

FATHER 12. Name... *Charles William Uhl*

13. Birthplace... *Hellersburg Pa*

MOTHER 14. Maiden name... *Nellie Threlkel*

15. Birthplace... *Mt. Savage*

16. Informant... *Margaret E. Uhl*

Address... *Mt. Savage*

17. *Burial* Date thereof... *5-17-46*
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematorium... *St. George*

Location... *Mt. Savage, Md.*

18. Funeral director... *J. J. Buehler*

Address... *1320 Washington Rd.*

19. *5-17* *47* *Vernon A. Demet*
(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *May 14th 1946* at *3:15 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *5-13-46* to *5-14-46* and that I last saw him alive on *5-14-46*

Immediate cause of death... *Pulmonary Oedema* DURATION *1 week*

Due to... *Myocarditis* *4 years*

Due to... ..

Other conditions... ..

(Include pregnancy within 3 months of death)

Major findings of operations... ..

Date of op.

Autopsy results... ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... .. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... *William E. Musely M.D.* M. D. or other

Address... *Mt. Savage Md.* Date signed... *5/16-46*

RECEIVED
MAY 24 1946
BUREAU U S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

04437
Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany Co
 City or town... Cumberland Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
Cumberland ymca
 How long in hospital or institution? ..

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State... Maryland County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... The Dringle
 (If rural, give LOCATION)
 2.(a) If veteran, name war ..

3. (a) FULL NAME

John Isaac Vandegrift
 4. Sex Male 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Francis Vandegrift
 6.(c) If alive, give age .. years

7. Birth date of deceased (mo., day, yr.) May 13 1881

8. AGE: Years 65 Months 15 Days 15 If less than one day .. hrs. .. min.

9. Birthplace Near Romney Wva
 (Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Builder Of houses

12. Name William L Vandegrift

13. Birthplace W.Va

14. Maiden name Margaret Haynes

15. Birthplace W.Va.

16. Informant Edward Vandegrift
 Address Cumberland Rd Rt. #3

17. Burial Date thereof May 31, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill
Cumberland Md
 Location ..

18. Funeral director John C. Wolford
 Address Cumberland Md

19. May 29 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

214-12-3978

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 28th 19 46, at 1 P .. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28th 19 46 to May 28th 19 46
 and that I last saw him alive on May 28th 19 46

Immediate cause of death .. DURATION

Coronary Thrombosis 2
 Due to .. months

Myocarditis 3 yrs
 Due to ..

Other conditions ..

(Include pregnancy within 3 months of death)

Major findings of operations ..

.. Date of op. ..

Autopsy results ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .. Date of ..

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ..

Means of injury .. Injured at work?

23. SIGNATURE P. L. Owens M.D. M. D. or other

Address Cumberland Md Date signed May 29-46

RECEIVED

JUN 4 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Allegany
 City or town..... McCool
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... one year
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... West Virginia County..... Mineral
 City or town..... Warnock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Katherine Warnock

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... April 20, 1861

8. AGE: Years..... 85 Months..... 1 Days..... 6 It less than one day..... hrs. min.

9. Birthplace..... Terra Alta, West Va.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... John Stump13. Birthplace..... Donot know.14. Maiden name..... Elizabeth Matheney15. Birthplace..... Do not know.16. Informant..... David WarnockAddress..... Barnum, West Va.17. Burial Date thereof..... May 29, 1946

(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... WARNOCK Cemetery.Location..... Warnock, West Va.18. Funeral director..... W. V. 2ndAddress..... Piedmont, West Va.19. May 28 19 46 Registrar.....

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5-26 19 46 at 8-P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-15 19 46 to 5-26 19 46 and that I last saw h. er alive on 5-26 19 46

Immediate cause of death..... Cerebral Hemorrhage DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Jas A. Newcome MD M. D. or otherAddress..... Keyser W Va Date signed..... 5-28-46

RECEIVED

MAY 30 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17006

CERTIFICATE OF DEATH

044384

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 hrs. 10 min.

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 27 hrs. 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Little Orleans
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ezra Watson

3. (b) Social Security Number

215-20-8898

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Clarissa Ellen Mann

B. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

October 31, 1868

8. AGE:

Years

Months

Days

If less than one day

7764— hrs. — min.9. Birthplace Piney Grove, Allegany Co., Md.

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER

12. Name John D. Watson13. Birthplace Allegany Co., Md.

MOTHER

14. Maiden name Mary E. My Ginnis15. Birthplace unknown16. Informant John D. Watson (son)Address Little Orleans, Md.17. Burial Date thereof May 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Piney Plains Meth. ChurchLocation Piney Plains Md.19. Funeral director Charles R. BastAddress Hancock, Md.19. May 7, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5th., 1946 at 12.10 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

Extensive second and third degree burns of head, face, neck, trunk and extremities.

DURATION

27 hrs. 10 min.

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-3-46Where did injury occur? Belle Grove, Allegany, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) highwayMeans of injury coll. truck and auto. Injured at work? no23. SIGNATURE James H. Brown, M.D.
M. D. or otherAddress Cumberland, Maryland Date signed 5-5-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

MAY 14 1946

BUREAU V. E.